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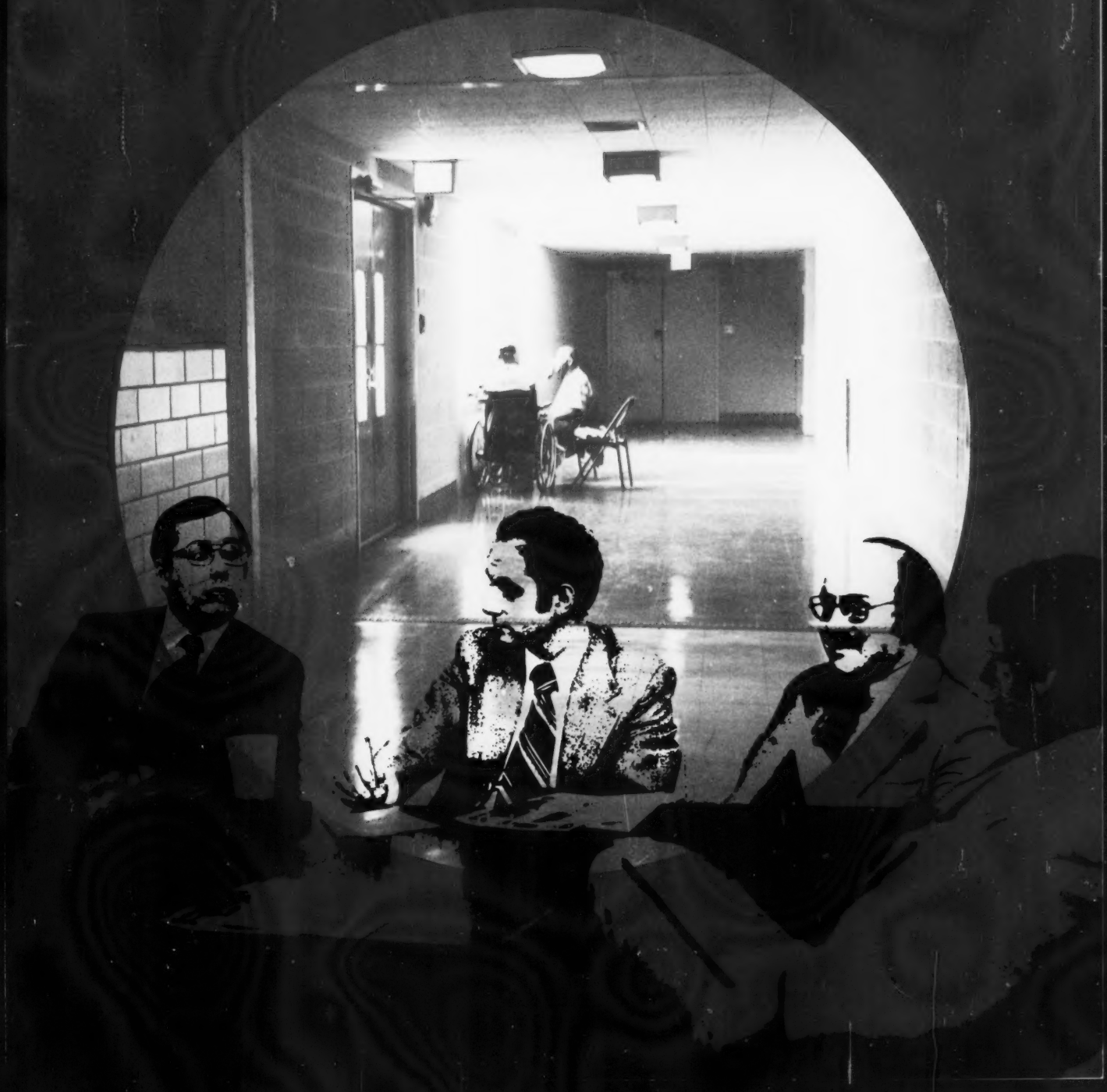
THE SOCIAL AND REHABILITATION

Record

December-January 1977



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THE SOCIAL AND REHABILITATION
Record
Volume 4 Number 1 • Dec-Jan 1977

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The Social and Rehabilitation Record is the official periodical of the Social and Rehabilitation Service of HEW. It is published 10 times a year by the SRS Office of Public Affairs. *The Record* is designed to provide information that will help professionals in State and local agencies and private organizations do a more effective job of carrying out programs which help people in need. The programs include social services for families and individuals, medical services, and assistance payments. Annual subscriptions are $6.40 (domestic) and $8 (foreign) and are paid to the Superintendent of Documents, P.O. Box 1533, Washington, D.C. 20402. Address manuscripts and article ideas to the Editor, Rm. 5327 MES Building, SRS/HEW, Washington, D.C. 20201. Telephone 202-245-2196. Publication funds were approved by the Office of Management and Budget on February 25, 1972, amended December 4, 1973.

The opinions expressed in this magazine do not necessarily reflect the views and opinions of SRS or HEW.

For the Record

This issue begins a new series of articles on Medicaid fraud and abuse which covers both the viewpoints of the providers and those charged with the responsibility for assuring the integrity of the Medicaid program.

The first of this series, which begins on page two, presents the viewpoints of nursing home operators and that of a consumer advocate representing the National Council of Senior Citizens.

In subsequent issues, articles will:

- Update the status of the second phase of "the war on Medicaid fraud," a term coined by SRS' Medical Services Commissioner.
- Present the Federal viewpoint in all Medicaid areas.
- Report on the successful techniques some States and counties have developed to detect, investigate and prosecute cases of fraud.
- Report on the progress of the new Administration as it makes fresh initiatives in all areas of Medicaid.

■

Robert Fulton, who became SRS' fourth Commissioner in June, has presented his resignation at the pleasure of the President. Major activities during his tenure included the establishment of the Office of Medicaid Fraud and Abuse Control and the Medicaid Management Institute.

■

The Record has received an Award of Excellence from the Society for Technical Communication for the overall quality of its September 1976 issue. The award was presented for "superior writing, editing and graphics." *The Record* was one of three magazines which received this award.

Martin Judge

Do Nursing Homes Deserve the Heat They've Been Getting?

To review the advances and the shortcomings in the nursing home field, The Record *invited representatives of both non-profit and for-profit nursing homes as well as a representative of the consumers to a round table discussion at SRS headquarters in Washington. Those taking part were:*

- *Bruce Thevenot, administrator of the American Health Care Association's Government Services Division. The association is a national trade association with a membership of about 7,500 licensed facilities caring for some 600,000 persons. About three quarters of the members are proprietary; the remainder are government-operated or non-profit.*
- *Laurence Lane, director of public policy for the American Association of Homes for the Aging. This national association of non-profit homes accommodates about 200,000 elderly persons. Members range from independent housing units to skilled nursing homes.*
- *Daniel Seikaly, staff attorney for the National Council of Senior Citizens. The organization represents some 3.5 million persons.*
- *Jack MacDonald, executive vice president of the National Council of Health Care Services. The association represents multi-facility nursing home firms, whose member facilities accommodate more than 75,000 long-term care patients, with many facilities providing out-patient services. The association requires that its members are licensed and are eligible for accreditation set by the Joint Commission on the Accreditation of Hospitals' Accreditation Council for Long Term Care Facilities.*

The opinions expressed in this discussion do not necessarily reflect the views of SRS or HEW.

THE RECORD: The nursing home field has been under fire for some years for various reasons, first for lack of adequate safety and services and more recently for Medicaid fraud. How wide spread are such practices?

THEVENOT: The nursing home profession has its share of individuals with felonious motives and it has others who simply are poor managers. Some are committed to making a fast buck rather than to quality health care programs.

We acknowledge that problem. On the basis of the evidence that we now have, fraudulent practices among health care providers seem to be particularly virile in large urban areas, which is typical of other parts of the health care delivery system. I think the root causes of the problem can be traced back to the fact that public programs have dispensed enormous amounts of money with relatively few effective controls. There have been controls and paper requirements, but they have not been effective in weeding out the potential at least for both fraud and abuse.

We are attempting to do what we can as associations to deal with it, but the practical and legal limits on associations are quite real indeed. We would submit that the first responsibility falls upon those agencies which have legal authority to do something about it, and that is why we are cooperating at every step along the way with your Medical Services Administration's current fraud and abuse initiative and with the Congress in its development of new legislative authority to deal with the problem.

LANE: I feel the Federal Government has been a very poor purchaser of services. The reason is in part because the statutes under which we are working cause us to spend too much time trying to categorize the patients according to programs. We should be trying to determine their needs and shape the programs to fit them.

The system has more encouraged fraudulent practices than wise consumption of services, and the Federal Government has failed to really monitor the type of care that is being given. We have inspectors who are, for all practical purposes, building code observers. They go into a nursing home and tell you whether or not the boiler works, but they do not say whether the patient is receiving the exact care that he needs.

SEIKALY: I find myself in an unfamiliar situation — agreeing to some extent with the providers. We have come to this state of affairs

EXIT

because nursing homes and long-term-care facilities have been the stepchild of either health care policies or welfare policies. It is all a matter of unforseen side effects. Who would have thought that Medicare or Medicaid would have fostered the kinds of conditions we see in nursing homes today? The fact that inspectors look at building code violations rather than quality of care is as much a fault of Medicaid as any single cause that I am aware of. So I agree that there has to be better, more and different Federal involvement, but not necessarily the Public Health Service's method of assessing the care and progress of the patient.

I feel that method, the PACE Instrument, will do about the same thing with the patient that current evaluative techniques do with homes. A particular prognosis or diagnosis will require this kind of care and no other. You cannot individualize treatment under a PACE Instrument any better than you can today. What I would like to see, is a national long-term-care policy tied to national health care.

But since we began by talking about abuse, it is amazing that you do not see the kind of abuses in hospitals — in acute-care hospitals — that you see in long-term-care facilities.

THE RECORD: Why is that?

SEIKALY: Well, in part, because of the community involvement in hospitals. You visit patients there on a pretty regular basis, at least most of the patients there. That is not true in long-term-care institutions. In hospitals there is a lot more involvement by the medical profession. Trained individuals are providing care in acute-care hospitals. That is not the state of affairs in long-term-care institutions.

MacDONALD: I have to disagree with the point about how much more fraud or abuse or malpractice is going on in nursing homes than in hospitals. The malpractice area alone would somewhat contradict that assumption in that it has been centered in the hospital segments of the health industry. You can also look at some of the recent findings concerning the

"There are a number of intangibles which you simply can't buy even with a tougher reimbursement rate . . . that really determine the quality of care. One is community involvement."
Seikaly

accreditation of hospitals in California, both in their mental facilities and acute-care hospitals. Without question, general attention has been focused on the nursing home industry, but for many reasons that are unrelated to fraud and abuse. However, as a result of this general attention, each problem for the whole spectrum of the health care field has been spotlighted and magnified out of proportion in the case of nursing homes.

I would not argue with the other point that there is a need to bring the long-term-care segment into the health system and into the forefront a little more in regards to Federal health policy planning. However, I think that first there needs to be a basic policy decision as to whether or not nursing homes and long-term health care are to be limited to the medical model of a health system or whether or not they should be a part of a model composed of a combination of medical, social and psychosocial components.

That decision needs to take into consideration the characteristics of the population to be served by such a system. For example, about four years ago, the Stanford Research Institute evaluated the chronically ill population and found that while the elderly are a significant part of it, there were other significant groups of patients which were unrelated to age. That finding is being borne out today in that we are beginning to see a greater number of characteristics which are variable on patient profiles in nursing homes than we used to — not necessarily in every instance, but in a significant number of cases.

Before we can make a decision about the role of long-term health care in national health insurance, we need to make a conscious decision as to whether it is to be limited to the medical model of a patient's needs. Then, if the answer is yes, we need an additional system to provide services to the elderly or a given population based on their long-term medical, social and psycho-social needs. I do not feel that this question has been addressed by Congress, by HEW or by government circles generally. Nor has it been fully addressed by the long-term-care industry.

LANE: This is a very crucial point in the context of long-term care. Present policy attempts to use the same instrument to meet the need of two different patient populations. When you use the medically-oriented system, which has consistently been reinforced in Medicaid utilization review determinations being made on strictly medical principles, you are turning long-term-care institutions into acute convalescent facilities and post-hospital convalescent facilities. That is not the patient population we should be addressing.

While those needs should be addressed in a medical type situation, there is a second population which is larger, your chronic long-term-care population whose needs are psycho-social as well as medical. For them, the facility becomes their home. Thus far only very poor attempts have been made to integrate psycho-social needs.

For instance, Title XX severely limits the type of services that can be brought into a home for the aging, a residential-care facility or even a 202 housing project. Those persons who have made a facility their home are just as much in need of services as those who live in their own homes. Perhaps there are alternatives to the medically-modeled nursing home that are institutional, but are not necessarily a nursing home.

THE RECORD: How would providing these additional services affect cost?

MacDONALD: Well, if you were to just look at pure costs, then we are talking about the need for increased spending, but in terms of the per patient cost over his lifetime, it would be a reduction.

The Stanford study that I mentioned earlier said that there could be a possible 10 to 15 percent reduction in the cost of health care per person over his lifetime.

We need to look at the total picture, rather than emphasizing how much X number of days per illness costs in a nursing home as compared to home health care or to a hospital.

We have been using this latter type model for the last six to eight years—

"The system has more encouraged fraudulent practices than wise consumption of services and the Federal Government has failed to really monitor the type of care being given."

Lane

and it has not worked. The reason is that such a system is based on absolutes, and you have the problem of fitting people into little boxes according to a given diagnosis. A patient is either covered under the Medicare and Medicaid programs or he is not. This can result in a long-term-care patient having to leave a facility or being declared ineligible for services because a given benefit has been exhausted for a given coverage. Then, when the condition becomes severe enough, he may again have his eligibility and coverage redetermined and again begin receiving care under a program. This means that the system has to readmit him and start its administrative and rehabilitation process for that patient all over again. It is these types of in-or-out decisions in the long-term-care area that, I think, have resulted in much of the increase in the cost of long-term care.

THEVENOT: What we all seem to be saying in one manner or another is that we have a segment of the population which, because of chronic illness or physical disability requires some combination of social supports, income assistance, or even direct medical care, and we have not quite figured out where to fit these people into the health care system or if we should fit them in at all.

I suppose the ideal would be an integrated system where we consider each individual's needs and have at our disposal an infinite variety of social services, income maintenance capabilities, health and medical care services, and just conveniently, arrange the proper mix of services for each person. That sounds very idealistic, but I believe that is the direction in which we ought to be headed.

In fact, Senator Humphrey in the last two Congresses introduced legislation of this kind as an experimental authority and I am sad to say that Congress has not really considered that approach.

Because of the complexity of the population we are talking about, there are many unknowns about the cost of a fully integrated system where you have the best possible combinations of resources to bring to bear on a person's problems. So we need to

experiment with such a system. We need, for example, to know what savings, if any, might be realized by substituting new kinds of arrangements for some of the inappropriate things we are doing now.

There will always be a substantial number of persons whose needs can only be met through full-time institutional care. We favor studies on who should and should not be institutionalized. I know there have been studies on various aspects of this problem, but I am afraid they have been disjointed, and the Government has never attempted to really define an entire system in an experiment.

I believe it would have to be done in an entire State or several States or a metropolitan area. We need this experience before we can seriously consider a comprehensive long-term-care benefit program as part of a national health insurance bill.

I also think we need to distinguish in our thinking about long-term care those individuals who require relatively short-term recuperation or convalescence from a medical condition. The nursing homes play a role in that area, of course, and I think they should continue to play a role as providers of outpatient services and whatever appropriate services can be put together to meet a convalescent need. There is a real place for this in a national health insurance program because it is a better use of resources, reducing unnecessary hospital days. I think we have the resources to deal with that need in our population, but the one which we have not adequately addressed is the real long-term health care needs of perhaps a million and a half to two million people in this country.

THE RECORD: While your organizations support the anti-fraud and abuse effort, you have on numerous occasions fought changes in standards. When you get down to it, isn't the major concern of providers reimbursement?

THEVENOT: Yes, there have been instances in which the industry has opposed specific proposals for changes in the standards for various sound reasons. In some cases it was a question of reimbursement; at other times we have offered alternatives which we believed to be preferable from the standpoint of patient care.

LANE: Within SRS you have Title XX, medical services and other programs, but there has been only a limited attempt to coordinate and integrate the programs. Regulations are usually written which focus on one program at a time and, generally, the focus is on the bottomline—what is it going to cost HEW—rather than what the impact is going to be on the resident of the facility and on the community which is trying to provide that service. There are some tremendous examples that have already shown the cost-benefits of integrating services and providing a range of options beyond just a strict medical or a strict income maintenance program.

SEIKALY: I think the significance of the small scale experience is extremely important—the fact that high quality care is being provided, not just in campus settings, but in virtually every setting. One can point to several programs across the country that are providing very high quality care under exactly the same limitations—under Federal programs, including Medicaid.

These programs prove that there is no excuse for poor quality care. And we say that it cannot be measurably improved until there is a national long-term-care policy. I just don't buy that.

We ought to work in tandem. There has to be a long-term policy that is integrated, but is only part of a health care continuum. But while we are developing that in the future, we really have to crack down—and that is both a Federal and a State function — onproviders who do not live up to the standards that the profession maintains its members should.

THEVENOT: We recognize that our success in advocating various reforms in the system is always obscured by examples of individuals defrauding the program. This substantially affects our credibility. We think we have some very good suggestions based on practical experience in delivering health care that people

are not listening to because our credibility is often hampered.

I would like to go on record as acknowledging that problem and say that we need to deal with it. I think, however, there is an assumption, at least implicit in our words, that the quality of care in nursing homes in the United States is uniformly substandard—that no progress has been made over 10 years—and I would just like to say in the strongest possible terms that I do not think that is the case.

The vast majority of nursing homes in this country are providing extraordinarily good care, given the circumstances and the resources they are given to work with, and even the harshest critics of the industry have acknowledged that most nursing homes certainly provide an acceptable quality of care. It is not luxurious in many cases and it falls short of acceptable standards in the minds of many Americans in other cases, but to imply that some of the conditions that have been discovered in selected instances are typical of the whole profession is certainly a gross misinterpretation.

THE RECORD: But doesn't it come down to the fact that you either comply with the standards or you don't?

LANE: Are you primarily talking about physical standards—the physical plant—or the care?

THE RECORD: Both. Isn't the problem of inadequate staffing and inadequate delivery of an appropriate level of care increasing?

LANE: The primary thrust of our policy has been improvement of long-term-care programs. But if you are asking why they are deficient, one of the primary causes is inadequate reimbursement. Why is the Government not providing sufficient reimbursement to these facilities? Of our homes that take Medicaid—ICF and SNF patients—about 60 percent report Medicaid reimbursement meets less than 70 percent of their operating costs.

We do have the advantage, of course, of being able to bring in charitable donations because we are non-profit, and that helps supplement the inadequate reimbursement.

"The root cause of the problem (fraud and abuse) can be traced to the fact that public programs have dispensed enormous amounts of money with relatively few effective controls."
Thevenot

THE RECORD: The Federal Government pays from 50 to 78 percent of the cost with the matching rate determined by . . .

LANE: No, we are talking about reasonable reimbursement costs. Section 249 of Public Law 92-603 required the cost-related reimbursement by July 1, 1976, however, HEW has delayed implementation. Where plans are going into effect, some States have put arbitrary ceilings on their funds for Medicaid. They have also set up classes that discriminate in their reimbursement.

THE RECORD: If there are some nursing homes in various areas of the country that provide quality health care—that is, meet the Medicaid standards, given the Medicaid reimbursement level—why can't everybody do it?

MacDONALD: If you go into a facility that most of us around this table would categorize as a very top facility and look at the patient profile, I would venture that no more than 50 to 60 percent of them would be Medicaid or Medicare patients. Private patients are making up for the losses incurred as a result of the Medicaid and Medicare patients.

THEVENOT: It is rare indeed to find an institution which has almost all Medicaid patients that is providing a very high level of care. They may be providing an acceptable level of care, but the fact is that Government programs are not purchasing very high quality care in the sense of any amenities, perhaps even in the sense of adequate staffing.

The fact is the programs are purchasing very minimal services. From visiting a lot of homes in many, many States, I find those facilities that have any amenities at all—that have large numbers of staff people and voluntary programs—are financing that level of care from charges to private patients or from philanthropic sources and other sources.

SEIKALY: The quality of care in nursing homes is not dependent on whether a home is a profit or non-profit home or the number of Medicare/Medicaid patients in a particular home, even though you could always find individual circumstances where that appears to be the reason.

There are a number of intangibles which you simply cannot buy even with a higher reimbursement rate, and those are what really determine the quality of care. One of those is community involvement, which I think everyone would recognize has a great impact.

Community involvement tends to focus on the non-profit homes, so it is a tremendous advantage for them. Somehow it is hard to work up an auxiliary to a for-profit institution, but the nursing home ombudsman projects in several States—including Michigan, with which the National Council of Senior Citizens worked for several years—has had a great impact on the quality of care in both for-profit and non-profit homes. Under that program volunteers, relatives and non-relatives went into a home. Their presence bolstered morale for the staff and also acted as a watch dog for medical and non-medical staff. Naturally, there was no increase in Federal, State or other funds, but there was a perceptible increase in the quality of care.

I do not think anyone would challenge me on the assertion that Federal and State enforcement mechanisms are weak, even where legislation exists, such as California, New York and Florida. Yet, in situations where the community has come in and community advocates have been trained and operate on a regular basis, enforcement mechanisms have sprung up. So I do not think it is all a matter of money.

LANE: When you have your cost ceilings for medical services and for the physical plant, you often can't stretch the dollars to cover the social aspects of residential living. Because of this the resident loses some of the necessary supports which contribute to life satisfaction within the facility.

But unless SRS is going to grapple with the issue and underwrite social supports in addition to medical supports, many nursing homes are likely to become pretty bleak places.

THE RECORD: Exactly what type of social supports are you advocating?

LANE: An example would be social workers who provide creative activities and bring in community activities. Somebody is going to have to pay for these services.

We have underwritten some social supports with charitable donations, and some of our members have established working relationships with area agencies on aging or the ombudsman program. But SRS has, within Title XX regulations, prohibitions against the use of Title XX monies within institutional settings. Why?

THE RECORD: From the Federal viewpoint social support is part of what we are paying for. If a facility is not providing that, it is out of compliance with Federal regulations.

MacDONALD: But that does not solve the problem. The facts of life are that when a State agency goes in and presents its budget to the State legislature, it will say that the State has X number of dollars and Y number of residents needing nursing home services. Therefore, we will be able to pay up to $\frac{x}{y}$ per patient day for skilled nursing care. Then the agency will attempt to break down the rate and say that of the total rate they are going to allow Z dollars for construction and improvements in existing facilities to meet the Medicaid standards. That allowance may or may not be enough to meet the actual cost of the improvements. Therefore, any loss must be made up in other areas.

This allocation of costs carries over into direct patient care areas where you see such things as State Medicaid agencies allowing reimbursement for a total of two hours of nursing services. Now, I really question the ability of a facility to provide a skilled level of care, as defined by the Federal regulations, based on two hours.

THEVENOT: We ought to be realistic enough to know that the Government is simply not going to provide open-ended funding for all of the kinds of health services that people need or think they need—all of the kinds of things that the human mind can devise as worthwhile services. I think for some time to come, because of the very real concern of the Congress about the cost of health care generally, and particularly the amount of public dollars being poured into the health care sector, that we are not going to see any sudden authorization of new programs to bring into being some of the things we have been advocating. ■

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Medicaid. Worth looking into.

New Program Saves $150 Million in Child Support Collections.

Second year savings expected to exceed $400 million as State programs shift into higher gear.

by Frances Killpatrick

This year thousands of parents, mostly fathers, are paying millions of dollars in child support payments for the families they left behind. The reason is that the Child Support Enforcement Program which began operation August 1, 1975, is doing even better than officials had hoped.

HEW had predicted that the program would break even the first year. Instead, child support collections exceeded the cost of collections. More than $280 million was collected at the cost of about $130 million for fiscal 1976. And States estimate total child support collections for fiscal 1977 will exceed $400 million.

After a year of operation, one thing is obvious. A State can collect far more than it costs to administer the program.

Twenty-seven States collected more than they spent. On that basis, Robert Fulton, who is director of the program as well as Administrator of SRS, said in his year-end report: "Child Support Enforcement is cost effective and a sound management practice."

The 10 top child support collectors are Michigan, California, Massachusetts, Ohio, New Jersey, Pennsylvania, Washington, Connecticut, Minnesota and Maryland. Their combined annual collection returns are over $200 million.

The legislation for the program, technically known as Title IV-D of the Social Security Act, was passed by Congress in late 1974. Its purpose is to locate absent parents, to enforce their responsibilities for support and to establish paternity. The program is carried out by each State, under its own laws and procedures, with the Office of Child Support Enforcement setting standards, approving State plans and providing other technical and organizational assistance.

State incentives

The Federal Government pays 75 percent of the State's costs. Another incentive for States to operate this program is that they are allowed to use a portion of support collections to reimburse welfare payments, thus reducing their own public assistance expenditures. On the other hand, States face a five-percent reduction in their Aid to Families with Dependent Children reimbursement if an audit shows them to have ineffective child

Francis Killpatrick is a freelance writer specializing in social services.

Drawings courtesy of U S News & World Report. Copyright 1976

support programs.

When the law was first enacted only a handful of States had organized child support programs. Today almost all States are operating a program and the rest are moving to implement them.

Locator service

One of the important results of the first year of the program is the development of the Federal Parent Locator Service, commonly referred to as the PLS. The PLS is one of the requirements placed on the Department by legislation. It is designed to help States locate absent parents in order to collect child support from them.

One of the first steps in securing child support is to determine where the absent parent is living. If the child's mother doesn't know, the State must try to locate the parent by checking with such sources as friends, relatives, current or former employers of the absent parent, or by checking records kept by agencies such as motor vehicles or unemployment compensation. However, if the State's efforts fail, it may then ask the PLS for help.

The PLS is empowered to obtain the last known home address or most recent place of employment from records of Federal agencies. It currently receives address information from the Social Security Administration, the Internal Revenue Service, and the Department of Defense. Plans are underway to add the Veterans Administration and the Civil Service Commission.

So far the States have made more than 130,000 requests for assistance to the PLS since it began operation on March 15, 1976. The PLS has been able to find an address for about 70 percent of the cases that have been referred to it. After returning the address information to the State that has requested it, the PLS destroys the information about the absent parent.

Although the PLS service is not a substitute for State and local work, it is proving to be a valuable resource when all else fails.

"We've done everything humanly possible to safeguard the PLS and prevent abuses from occurring," says Louis Hays, deputy director of the Office of Child Support Enforcement. "We believe we have been able to help the States obtain important rights for children and still protect the rights of absent parents."

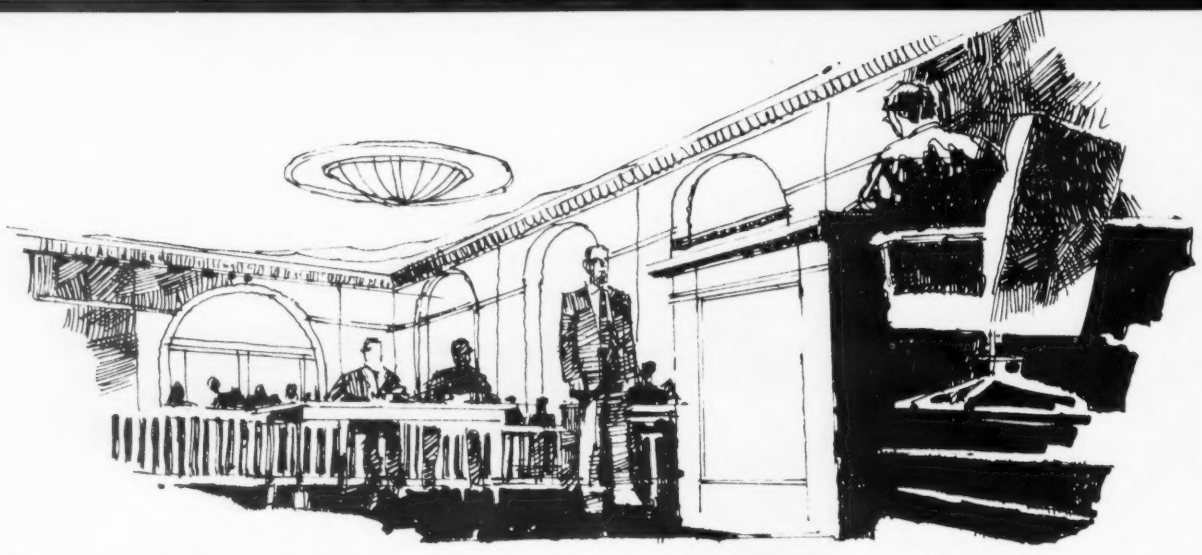
Critics of the program said it would be a waste of money to pay for tracking down absent parents because they could not afford to pay support. However, Mr. Hays reports that a year of experience shows about half the parents are able to pay some amount of child support. Indeed, some have been able to pay enough to remove their families from public assistance altogether.

How the States ranked

Michigan leads the list of child support collections with some $60 million the first year of the program. Its administrative cost of collection was around $8 million. One reason support collections in Michigan have increased rapidly in the last few years is that the State has paid considerable attention to the problem of nonsupport. Unlike most States, it has had an Office of Friend of the Court since 1919 which has been delegated certain enforcement responsibilities by the court.

The numerous manhours of interviewing and investigating by case workers have resulted in the State locating nearly three-fourths of its runaway parents.

Massachusetts reported collections of over $16 million at an administrative cost of under $3 million. New Jersey's returns were over $13 million



for an expenditure of $8.5 million. Other figures for States with high collections are Pennsylvania with collections of over $12 million, cost $2 million; Ohio with collections of $16 million, cost $2 million; Washington, with collections of $11 million, cost $3 million.

Virginia is an example of a State off to a solid start. While awaiting further legislation to strengthen the program, Virginia still collected over $3 million at a cost of $1 million.

Among encouraging signs are that collections generally are increasing quarter by quarter. Within the next year or so, officials expect to be able to judge how the program will work on a long-range basis.

Initial criticism that the program would be used to harass AFDC recipients has largely dissipated, according to Mr. Hays. The safeguards built into the PLS also have helped dispel the Big Brother image.

"This program is unique in that it not only helps people by bringing benefits of child support and establishing paternity," said Mr. Hays, "but it also creates savings for the taxpayer. I am very optimistic about the program, and I expect it to become even more effective." ■

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THE SOCIAL AND REHABILITATION **Record**

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HOW TO

Do a Better Job of Managing the AFDC Program

The Assistance Payments Administration of HEW's Social and Rehabilitation Service is acting as a clearing house for reporting on ways in which States have moved to improve management of their Aid to Families with Dependent Children (AFDC) programs. A number of these "How They Do It" reports now have been published and are available without charge.

"How They Do It" publications include:

Managing the Intake Process in Income Maintenance—*Minnesota, Washington.*

Photo I.D.s—*New York.*

Supervisory Review of Case Actions—*New Mexico.*

Work Measurements and Workload Standards as Management Tools for Public Welfare—*Michigan.*

Child Support Payments Control—*Massachusetts and Washington Bank*

Distribution (of Assistance checks)—*Pennsylvania and Nassau County.*

State Monitoring of Local Office Performance—*Maine, Washington.*

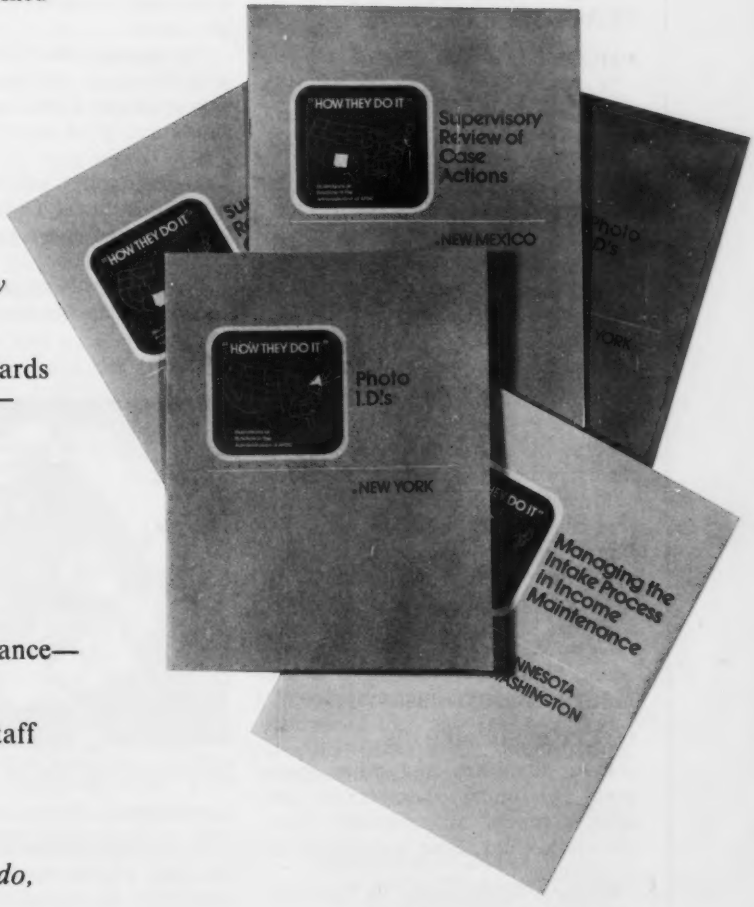
Managing a State Income Maintenance Staff Training Program—*Florida, Texas.*

Fraud Control—*California, New York.*

Wage Record Clearance Systems—*Colorado, Oklahoma.*

Recipient Response Forms Utilized in AFDC—*Selected States.*

Improving AFDC Operations Through Management Controls and Use of Error Profiles—*West Virginia.*



For copies, write:

Assistance Payments Administration
State Systems Management Division
Social and Rehabilitation Service, DHEW
Room 1232-B
330 C Street, SW
Washington, D.C. 20201

States compare rolls to uncover AFDC fraud.

Neighboring States are finding that a crosscheck of their AFDC rolls can uncover cases of fraud and reduce welfare costs.

A crosscheck of Michigan and Illinois records resulted in removing 19 persons from Michigan's AFDC rolls for an annual savings of $64,000. Illinois expects similar savings.

In all, 48 recipients were investigated in both States. Twenty-nine were found innocent of wrongdoing. They had simply moved from one State to the other and were in the process of establishing eligibility in their new home State.

Michigan is negotiating a similar crosscheck with Indiana and Ohio. Illinois earlier this year conducted a more limited review with Indiana and is working on a more extensive review with that State and with Missouri.

Beepers alert caseworkers to crisis situations.

Like physicians and other emergency personnel, caseworkers are using beepers to respond more quickly to child abuse and other crisis situations.

Sixteen caseworkers in Newark, N.J., who have been specially trained to handle crises, are using beepers when on emergency duty and after normal working hours.

"They have greatly improved our ability to act quickly in an emergency situation. I only wish we had more of them," said Robert Lease, coordinator of emergency units for the Division of Youth and Family Services.

The annual cost of the beeper system is $1,060 which includes equipment rental, unlimited paging service and maintenance. The cost of the system is said to be offset by more efficient use of staff time.

Medicaid fraud is target of new audit system.

A new computerized auditing system is expected to recover at least $8 million from New York City physicians who are said to be overbilling Medicaid.

The system provides investigators with physician and patient profiles, listing the physician and patients by name, and gives specifics of the billings.

Audit findings will be turned over to Manhattan's District Attorney who has been investigating Medicaid abuses.

The audit will focus first on those doctors billing Medicaid for $25,000 or more.

Improving child care services.

A training program to help sharpen the skills of child care staff, including many who have received no previous training, has been launched by the Texas Department of Public Welfare.

An innovative aspect of the program is a fleet of 16 vans, which are staffed by child development specialists. These specialists teach day care staff how to make their own supplies from inexpensive materials commonly found around the home. The vans, called Sharemobiles, are expected to reach day care providers who have had little or no training.

In addition, statewide workshops and seminars will be conducted.

"We estimate the program could train as many as 42,000 child care staff serving nearly 200,000 children," said Jerry Southard, child development manager.

$34 million saving expected in AFDC and home relief.

AFDC and Home Relief payments in New York are expected to be reduced by $34 million a year after a survey is made to redetermine the eligibility of current recipients. (Home relief does not include Federal funds.) The survey, which is the third in a series, was conducted by mail for 320,000 cases. In the city's last survey some 10,033 cases representing about 30,000 persons were closed as a result of the survey.

The estimated savings is based on the expectation that more than 60 percent of the cases closed will not be reopened within six months. Half of the cases closed by previous surveys were reopened, but the city expects that rate to be reduced by its new reapplication procedure.

The survey questionnaire, which is printed in both English and Spanish, is designed to identify changes in family income, size, as well as verify the absence of the father.

City and State officials anticipate that additional savings in the millions will result from the reduction of some cash grants based on information received from the questionnaires and the conversion of some Home Relief cases to the AFDC rolls.

Day care centers used by few parents.

Few parents use day care centers, according to a U.S. Census survey of how children are cared for during the day.

This strikes a sharp contrast with the day care arrangements made by parents whose children receive government-financed day care. Of these 650,000 children, about 50 percent are cared for in centers.

Of the 41 million children three to 13 years old, 33 million are cared for by one parent when they are not in school.

The survey found that about two percent of the children of working mothers are placed in day care centers — less than any other type of day care.

Of the eight million children without parental care during the day, 2.1 million are cared for in the home by a relative. Another 1.8 million children, most of whom are seven to 13 years old, care for themselves.

Army reservists join welfare volunteer program.

Members of the Army Reserve's 519th Maintenance Battalion are serving in the volunteer program of Texas' Department of Public Welfare.

Thus far, the group has built wheelchair ramps, mowed lawns and provided pest extermination services at a number of homes. The reservists are also trying to relieve loneliness by presenting talk-show style programs for groups of elderly persons.

★International Note★

Western Europe is highest in social security spending.

Western Europe spends proportionately more on social security than any other region of the world, according to a report released in mid-December by the International Labor Office in Switzerland.

Social Security includes health insurance, unemployment insurance, and old-age, survivors' and disability pensions.

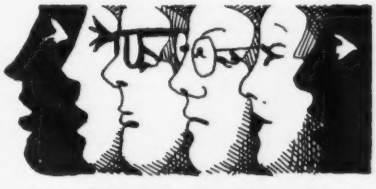
Eleven of these countries were devoting more than 15 percent of their gross national product to social security in 1971. They were: Austria, Belgium, Denmark, Finland, France, the Federal Republic of Germany, Italy, Luxembourg, The Netherlands, Norway and Sweden.

The Netherlands led all of these countries with 24.7 percent. Sweden followed with 25.2 percent. Countries with centrally-planned economies usually allocate between 10 and 15 percent of their "net material product" to social security. An exception is Czechoslovakia which devoted 18.1 percent.

Social security spending in many countries is rising faster than the national income.

Industrialized countries as a whole devote more than half their social insurance expenditure for old age, disability and death. The cost of medical care is also a major item.

The developing countries of Africa, Asia and Latin America devote less than five percent of gross domestic product to social security, a rate which has shown only a modest increase.



Sister Elizabeth Candon, a former president of Trinity College, Vermont, has been named Secretary of the Connecticut Department of Human Services.

William Toby, Jr., has been appointed SRS Commissioner for Region II (New York).

The Record invites notices of top-level appointments and news of State and local activities of interest to other professionals. Contact Patricia Fells, assistant editor.

Letters to the Editor

VR program alive and functioning in all States.

To the Editor:

I read with great interest the article entitled "New Statistics Replace Educated Guesses About Social Services."

On pages 10 and 11, we find a very interesting chart, which, if examined carefully, reveals that only 27 states in the union provide Vocational Rehabilitation services. This is particularly interesting, since anyone who takes the trouble to discover it, will learn that there is a living, breathing, functioning Vocational Rehabilitation program in every state in the union, and, indeed, some states have rehabilitation programs separated for persons with blindness. This is mandated by Public Law 93-112, the Rehabilitation Act of 1973.

Since this chart is grossly in error, I think you owe it to your readers to issue a correction in the next issue. I also wonder whether or not this example of the "new statistics" indicates that perhaps you should return to educated guesses.

Marvin O. Spears
Past President
Administrative and Supervisory
Practices Division, National
Rehabilitation Association

Under the Vocational Rehabilitation Act all States have vocational rehabilitation programs. Under Title XX and IV-B of the Social Security Act States may provide supplementary vocational rehabilitation services.
—The Editor

A Brief History of Social Services Part IV

by John C. Miller

This is the concluding article of the series.

The U.S. was often described in the 1950s and early 1960s as a society whose principal economic problem was the imbalance between the prosperity of the private consumer and the relative impoverishment of public institutions.

By the late 1950s the majority of social thinkers felt that the postwar prosperity of the industrial West was eliminating large-scale poverty.

The traditional gauges of economic-social well being — the unemployment rate, GNP, number of persons receiving public assistance, level of income, rate of home ownership — all indicated times were never better. The few references made to poverty at this time indicated that there were few poor persons in America.

A look at the Federal Government's spending for public assistance seems to support such a view. In 1960, the dollars spent on Social Security and public assistance came to 6.3 percent of the GNP compared with 11.1 percent for Great Britain, 12.4 percent for Sweden and 16.1 percent for West Germany. But statistics measure only what they are designed to measure and little note was taken of the 10 million persons who were being kept from the ranks of the destitute through Social Security checks.

The traditional gauges failed to portray an accurate picture of economic conditions throughout America because they were not designed to detect the poverty of "relative deprivation," or what came to be known as

John C. Miller, formerly a senior editor of several national business magazines, is a freelance writer.

During the Kennedy-Johnson Administrations a broad spectrum of social legislation was conceived and passed, with Johnson launching the War on Poverty.

the "new poverty." In The Great Depression, poverty was widespread but of limited duration. The poverty of relative deprivation was found to be concentrated in specific groups.

If it is possible to mark the moment when significant public attention was first focused on the new poverty it was in 1962 with the publication of Michael Harrington's book, *The Other America.* Disrupting the complacency of a smug America, much like *Uncle Tom's Cabin* of a century before, Harrington asserted that between 40 and 50 million Americans were in fact poor. Indeed, it was estimated that 38 million persons in the U.S. went hungry.

Prior to Harrington's book, America's poor had not been visualized as a permanent class. The American notions of social mobility and "anybody can be President" mitigated against thinking in terms of hard and fast economic classes. But it was no longer possible to ignore that a stratum of poverty persisted, unaffected by the growing prosperity of the majority. The notion of poverty became less elusive when a poverty line was drawn, though somewhat arbitrarily, at $3,022 per year for a family of four in 1960. By 1972 the poverty line for a family of four had risen to $4,275.

The new poor were the aged, unskilled, incapacitated, large families and minorities. These groups were found to have a high incidence of relatively permanent poverty. Certain geographic areas also had a relatively high incidence of poor persons: the inner cities and rural communities in the South, most notably Appalachia.

Surprisingly, the American poor were often employed — not unemployed. Historically, poverty and unemployment had been closely connected, but large-scale unemployment was not a prominent feature of the new poverty. In many poor families the head of the family worked, but the jobs they could hold required minimal skills and returned marginal wages. Such low income together with a high incidence of brief, periodic layoffs, largely explained how widespread poverty existed within a period of so-called full employment.

The publicity generated by Harrington's book and other studies of poverty in America resulted in a second look at the social services statistics. The fact was, that despite the extension of Social Security programs, about four out of every 100 persons were dependent on some form of public assistance in the 1960s. It was evident that both Social Security and public assistance hadn't eliminated the problem of poverty.

In 1962 and again in 1967, the Social Security Act was amended in relation to social services. The 1967 amendments established Federal reimbursement for a State which provides social services to encourage self-support and self-care, and maintain and strengthen family life. Later amendments limited spending for social services to $2.5 billion and Congress passed legislation establishing a new title, Title XX, which gave new impetus to social services.

Rather than simply expand traditional forms of public assistance as Social Security had been expanded, the Johnson Administration declared a War on Poverty.

The war was waged to meet the needs of the working poor, emphasizing development of depressed communities and job training programs.

The 1962 and 1963 Manpower Development and Training Acts supported the vocational training of adults and high school dropouts over age 16. And the Vocational Education Act of 1968 provided financial aid to students.

The keystone of the War on Poverty was the Economic Opportunity Act of 1964, the first full-scale Federal commitment to eliminating poverty in the United States. Anti-poverty legislation created: the Job Corps and Neighborhood Youth Program emphasizing job training; community action programs in which the Government committed itself to pay 90 percent of local anti-poverty efforts, including literacy training for adults; and rural anti-poverty programs, such as grants and loans to low-income families and the establishment of day care centers for migrant workers.

The act also established employ-

To help the disadvantaged move more easily into the mainstream of society, a number of educational programs was begun, some to give children a head start, others to offer remedial training. This effort was also extended to vocational rehabilitation.

ment investment incentives that granted loans to small businesses hiring minorities, a work experience program for training unemployed fathers and other needy persons, and set up the domestic Peace Corps, VISTA. The legislation guaranteed that a person could participate in these programs though he might receive unemployment compensation or some form of public assistance.

In 1964 a Family Life Act provided additional Federal funds to encourage the aged and disabled to remain in their homes and obtain medical help as outpatients. With the establishment of Medicaid in 1965, a new Federal-State mechanism was set up to provide medical services to the poor. Under the law, HEW provided from 50 to 78 percent of the cost of purchasing needed health-care services for eligible persons, and the States pay the rest, a few of them sharing the cost with local governments. The Federal share varied with per capita income in the State, and averaged 55 percent of total costs. Those eligible for welfare cash assistance (AFDC, aid to the aged, blind and disabled—now called Supplementary Security Income) were automatically eligible. States also had the option of including those whose income exceeds the cash assistance eligibility ceilings but whose large medical bills bring them within the ceiling when subtracted from income. A total of 32 States now have such a "medically needy" program under Medicaid.

In fiscal 1974, about 20 million persons received Medicaid services at a combined Federal-State cost of $9.7 billion. HEW estimates that 24 million persons will benefit from Medicaid in fiscal 1977, at a Federal-State cost of $18.3 billion.

Other anti-poverty programs of the mid-1960s included the Older Americans Act of 1965, which established the Administration on Aging and elevated the Welfare Administration's Office of Aging to agency status, the Housing and Urban Development Act of 1965 and the Child Nutrition Act.

The cost of fighting poverty was well documented. In 1963 and 1964 State and local governments spent $12.9 billion on the poor, not counting their share of Federal grants for public assistance programs that totaled $2 billion. Money spent to aid the poor by private groups brought the total that year to $17 billion.

Though the number of poor people in America decreased from 40 million in 1960 to 29.7 million in 1966, the cost of income maintenance (Social Security and public assistance) rose from $25.3 billion to $39.8 billion.

By 1966 HEW's annual budget had grown to more than $10 billion (30 billion when trust fund is included) and the department was administering 200 separate programs. In contrast, only six years earlier HEW was operating only 100 programs with a budget of $6.9 billion.

For the most part, the 10 million Americans in need of welfare services in 1967 were served by a vast patchwork system supported by Federal funds but administered by the States. Their eligibility requirements, operating procedures and benefits varied. The Federal Government in conjunction with private agencies and State and local governments was spending a total of $40 billion or about five percent of the GNP.

In an effort to increase efficiency and control, HEW's public assistance and rehabilitation programs were reorganized in 1967 into a new agency, the Social and Rehabilitation Service.

With its emphasis on a host of new social services programs, rather than on cash payments or the creation of jobs, the War on Poverty received mixed grades. Job training was successful mainly with those who did not require a massive upgrading of skills; the success of Head Start was not always easily demonstrated; community development did not strengthen the economic viability of every community in which it was undertaken.

Some social critics considered the social service-rehabilitation approach of the anti-poverty program inadequate; they claimed that neither public assistance nor pension programs provided enough hard cash to maintain recipients at more than a

bare subsistence level.

In that year, however, 30 million poor people in America were receiving the following:

- 33 percent of all Social Security benefits.
- 40 percent of health insurance for the aged.
- 30 percent of hospital care by the Veterans Administration.
- 20 percent of unemployment compensation.
- 30 percent of programs under Elementary & Secondary Education Acts.

The goal of getting people off welfare was thought to be secondary to providing aid to those who had no other source of income.

Though the pay-as-you-go, earned-rights concept of Social Security was generally accepted, much of the public never changed its traditionally negative attitude towards public assistance programs. To the upwardly mobile members of the affluent society, public assistance continued to symbolize personal failure and irresponsibility. The commitment of the Federal Government to billions of dollars in anti-poverty funds reawakened doubts about the welfare system and its growing number of recipients, of whom less than one percent were able-bodied men.

Between 1963 and 1968 poverty declined 38 percent. Further refinements in Social Security permitted more liberal coverage for the disabled, disabled widows and disabled dependent widowers. By the last years of that turbulent decade, 70 percent of all State and local government employees and all employees of non-profit organizations were brought under Social Security.

But the Social Security system's most significant addition of the period was Medicare, which was established in 1965. Health insurance was one of the most bitter battles in the political history of the country. As early as the turn of the century, politicians and social workers were calling for some kind of Government health insurance to pay for rising medical expenses. Between 1960 and 1970 alone, the cost of hospital services increased 150 percent. The breakdown of medical payments was private insurance, 26 percent of all health costs; the Government, 38 percent; individuals, 36 percent.

Medicare was available to those over 65 for a $6.70 monthly fee. In return, Medicare would pay 80 percent of doctor bills and for 90 days of hospital care for each specific "spell of illness." Also included was 100 days of care in a nursing home.

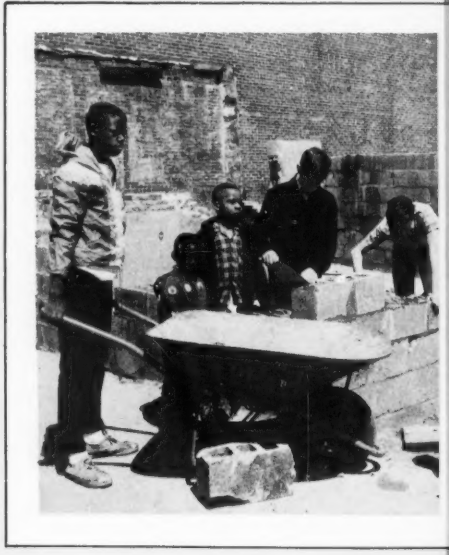
By 1975, 23.5 million persons were enrolled in the Medicare program and that year $10.4 billion in benefits were paid out. Under the paid medical insurance provision of Medicare, 74.3 million bills were paid in 1975 for a total of $3.6 billion.

In 1968, the Government began cutting back many of its social services directed at the working poor. To replace much of the old system, the Nixon Administration proposed $30 billion in Federal funds be given to States and local governments over a five-year period with relatively few restrictions on how the money would be spent. Four major revenue sharing programs were community development, education, manpower training and law enforcement.

Under the Better Communities Bill, most central cities with deteriorating areas stood to lose money while many suburban areas were slated to receive substantial sums for the first time. But after President Nixon vetoed bills on vocational rehabilitation, emergency medical care and rural development, his revenue sharing proposals were not enacted by Congress.

Some of the Nixon Administration's social services achievements include establishing the Office of Child Development in 1969, which was committed to improving the first five years of a child's life; establishing the National Center for Family Planning with a five-year goal of reaching the estimated five million low-income women of child bearing age who want family planning services but can not afford them; increasing by 16 percent the number of disabled persons (241,390) who were rehabilitated and became employed in fiscal 1969.

An extensive effort to help elderly citizens who suffer from malnutrition, isolation and other problems was mounted in 1971. SRS announced it would invest $4.1 million toward



A major emphasis of the War on Poverty was training poor persons without skills so they would be able to effectively compete in the job market. The 1962 and 1963 Manpower Development Acts supported the vocational training of adults and high school dropouts over age 16.

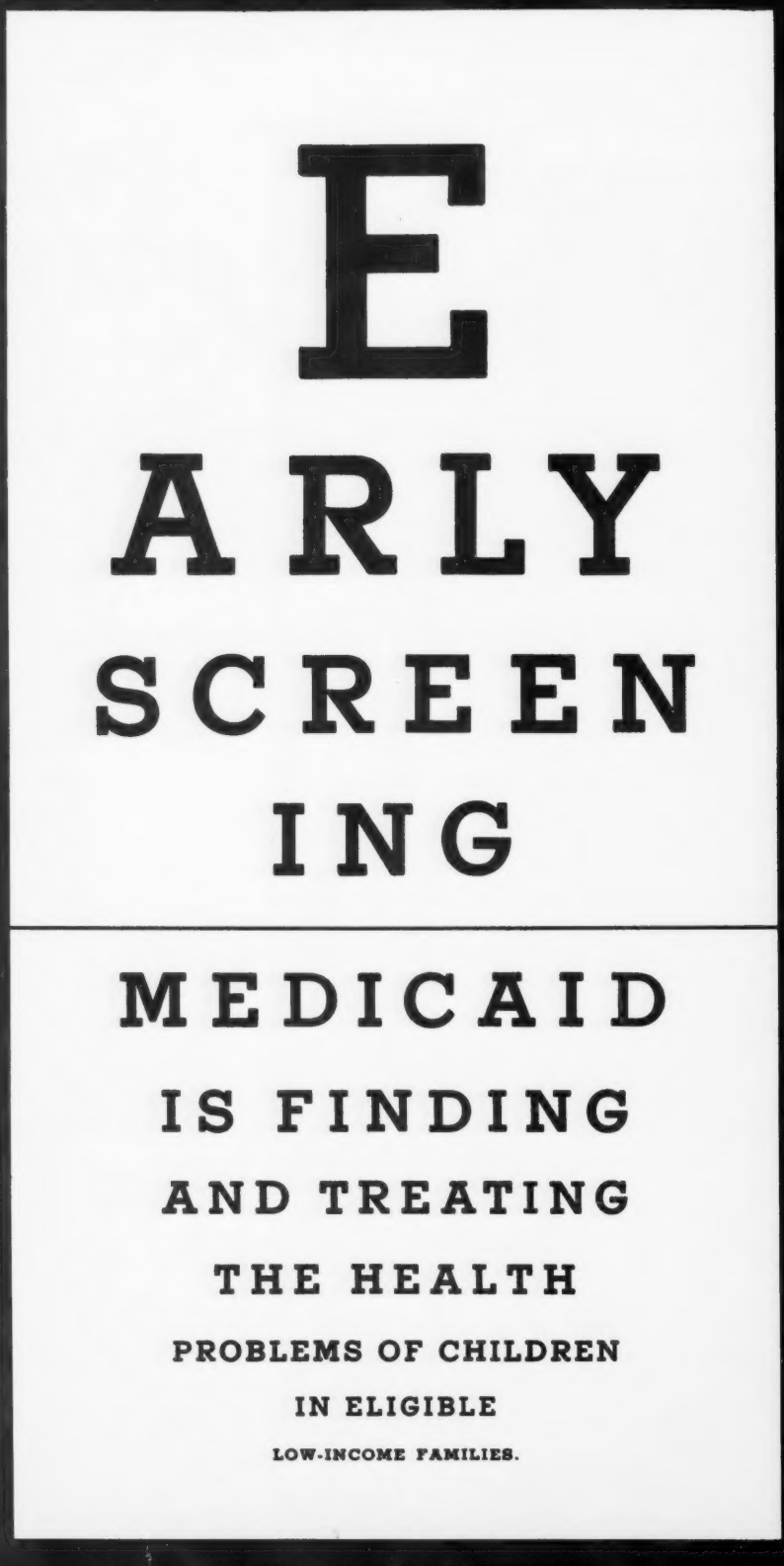
developing a national program of comprehensive social services for the elderly. And in response to a Presidential mandate to upgrade the quality of nursing home care for some one million elderly persons, HEW expanded nursing home inspections.

Though many War on Poverty programs were dismantled during the 1970s, due to the stalemate between Congress and the Administration over revenue sharing, the Administration attempted to substitute a national guaranteed minimum income in place of the existing welfare system. Called the Family Assistance Plan, the program would guarantee an annual payment of $2,400 for a family of four with no other outside income. One objective was to help the 50 percent of the poor who some said received no public assistance of any kind. The proposal passed the House twice but failed in the Senate.

In the wake of continued criticism of the welfare system, SRS issued guidelines under which States could thoroughly investigate the eligibility of AFDC applicants and recipients. Beginning as far back as 1962, SRS had instituted a Quality Control System to measure the rate of errors in eligibility, overpayments and underpayments. In 1973 the program was given greater emphasis and error tolerances were added to the QC System. States initiated an intensive AFDC sampling procedure in January 1974.

The first automatic cost of living increase in Social Security benefits became effective in 1975 after the country experienced double-digit inflation. The increase was eight percent and applied to all except those on special minimum benefit provisions.

The questions being asked today about how the poor can best be helped, who will administer the help and how the bill will be paid have been asked by every generation since the Middle Ages, and probably before. Different generations have found different answers, but basically they have wanted to help those who are in genuine need without wasting money on those who can provide for themselves. ■



For a free supply of this poster write: Editor, The Social and Rehabilitation Record, Rm. 5327 SRS/HEW, Washington, D.C. 20201

Publications and Films

Please address all inquiries and requests to the addresses in the listings.

Publications

Integrating Income Maintenance Programs. Editor, Irene Lurie. Institute for Research on Poverty, University of Wisconsin $7.50.

The staff of the University of Wisconsin's Institute for Research on Poverty examined interactions among the many cash and in-kind transfer programs that constitute the nation's income maintenance system. In July 1972, the Institute held a conference to present the papers it had commissioned and to discuss the implications for welfare reform contained therein. This is a collection of the papers first presented at that conference four years ago.

The chapters in the volume vary markedly in subject, treatment and intended audience. There are whole chapters devoted to analysis of how much in benefits is lost for each additional dollar of income under different program combinations.

Other chapters deal with welfare, the Social Security retirement system, unemployment insurance, Medicaid and Medicare, day care and interstate differences in benefit levels.

Competency-Based Education for Social Work: Evaluation and Curriculum Issues. Morton L. Arkava and E. Clifford Brennen, editors. Council on Social Work Education, 345 East 46th Street, New York 10017.

In this volume the issues of evaluation of the baccalaureat social worker and related curriculum development are explored, and models for these two issues as strategies are tested.

Part I presents an overview of the forces responsible for the move toward quality control in social work education. Different approaches to quality control are examined with a special focus on assessment efforts in social work and other professions.

Part II constitutes a detailed review of the University of Montana Department of Social Work experience in developing a summative evaluation for its graduates. Evaluation alternatives are considered through three perspectives: the psychology of individual differences, industrial psychology, and competency-based educational evaluation.

Part III consists of four critiques of the University of Montana experience.

Part IV, which consists of only one chapter, provides a base example of the development of a competency-based curriculum at the University of Calgary.

Reforming Public Welfare: A Critique of the Negative Income Tax Experiment. P. H. Rossi and K. C. Lyall. Russell Sage Foundation, New York. $10.

The New Jersey/Pennsylvania Negative Income Tax Experiment offered enormous opportunities to policy makers, as well as economists, sociologists, front-line administrators and case workers concerned with the seemingly endless perplexities of poverty.

The vast complexities of conducting the first such large-scale, controlled social experiment did not result in a clear and definitive statement on the actual success or failure of either the experiment or the concept of a negative income tax.

This publication enables the reader to obtain a much clearer understanding of the experiment, in addition to providing a valuable insight into the complex problems and issues that confronted the framers, administrators, and researchers of the experiment.

The various stages of development of the experiment are introduced with an emphasis on its administrative and research activities. The book is based largely on extensive interviews with the subcontractors of the experiment and on interviews and correspondence with the researchers and agencies involved with the experiment.

The origins and underlying theory of the Negative Income Tax are examined as they may be considered within the context of national welfare reform. After a brief but descriptive discussion on the design of the experiment, we are shown how the population for testing was chosen and divided into control and experimental groups; the decision factors for choosing the various sites and establishing an ethnic balance are also mentioned.

The book concludes with chapters on the "internal and external" politics of the experiment, and the authors' overview of the New Jersey Experiment and experimental research in general.

Queuing and Waiting: Studies in the Social Organization of Access and Delay. Barry Schwartz. University of Chicago Press $12.

Time is money for a variety of people in a variety of settings. This book organizes the various forces that come to play on both the provider and recipient of services. It starts with the premise that suppliers of services need to arrange their work in such a fashion that appointments can be made.

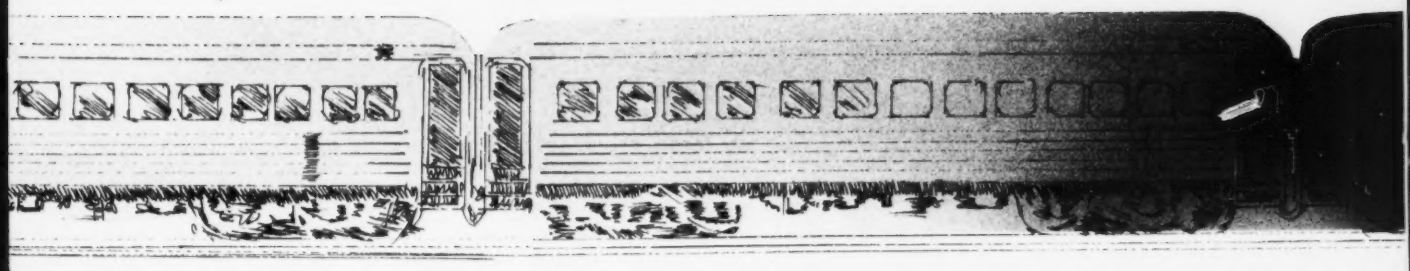
The book focuses on three specific points of reference: (a) waiting time; (b) the internal organization and order of queues; and (c) the major way in which delay is interpreted by clients and servers. A large section is spent on describing waiting and the significance of waiting in society. Waiting and the monopolization of services is described in various settings in the United States.

Films

Farewell to Welfare. Order Section, National Audiovisual Center (GSA) Washington, D.C. 20409. Rental fee $10; purchase price $90.

This film highlights the success of three women who were formerly welfare recipients. They are now earning good wages as a tractor-trailer driver, a picture framer, and a laborer at a cardboard manufacturing plant.

Police
R-75



Welfare Mothers Strike it Rich.

WIN program helps women break into good-paying jobs once reserved for men.

by Patricia Fells, Assistant Editor

"What kind of job are you looking for?" asks the employment counselor.

"Oh, something in the clerical field: typist, receptionist—something like that," is the all too familiar reply of the unskilled woman seeking a job.

Now women are getting far more jobs that have traditionally been open only to men. Some examples:

- A welfare mother in Cincinnati is today a tractor-trailer driver earning $500 a week.
- A Reno mother of three registered for a job as a waitress—her previous occupation—but was convinced to try picture framing. She is now the manager of the framing shop and training another welfare mother.
- In San Francisco a welfare mother was hired by a cardboard box manufacturer which hired few women. She is performing well and her goal is to be the first woman to operate a corrugating machine.

Jobs like these are opening to women due to the Work Incentive Program which was established in 1968.

"Our method of operation," says Merwin Hans, a WIN official, "is to first interest the applicant in a non-traditional job. Once that is accomplished, the total job development mechanism of the local employment office is used to find a willing employer. WIN then arranges for whatever is necessary to get her to that job."

The assistance WIN provides might take the form of day care for her young children or possibly job training. Another approach is to convince employers who are already involved in WIN programs to open up more jobs that have been traditionally reserved for men.

A case in point was WIN's contract with the Brotherhood of Railway and Airline Clerks whose members were traditionally male. The union had earlier proposed a job-training program for yard clerks and had received WIN funding for it.

"Since the union knew women did a good job," said Mr. Hans, "we enlisted its help to open doors to other jobs in the industry."

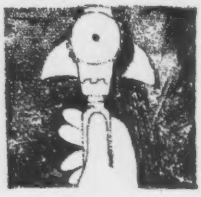
Some of WIN's more outstanding placements include:

- The first woman fiberglass mechanic with United Airlines. She earns $61 a day. This position offers a maximum earning potential of $20,000 a year.
- The first three women to be hired since World War II as mechanic-laborers by the Missouri Pacific Railroad. These women earn about $45 a day.
- The first three women hired as "train service operating personnel" with the Western Pacific Railroad. Their yearly earnings will range between $15,000 to $25,000.
- Two women placed as railroad car repairers and mechanic-laborer at salaries of $45 a day. Because of their fine performance these women have been promoted to engineer-trainees. An engineer's salary potential is $30,000 a year.

"While these are showcase examples they point up what can be done given willingness on the part of women to venture into something different, acceptance on the part of employers and persistance by job developers and counselors," said Mr. Hans.

WIN has produced a film it hopes will be a door-opener to other industries. *Fairwell to Welfare* highlights the success of the first three women mentioned in this article: the tractor-trailer driver, the picture framer, and the laborer at the cardboard manufacturing plant. The film is available from the National Audio-visual Center, Washington, D.C. 20409. It can be rented for $10 or purchased for $90. ■

Children should be seen.



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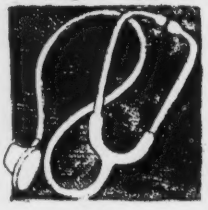
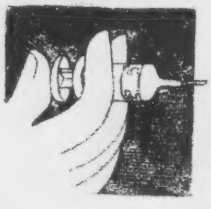
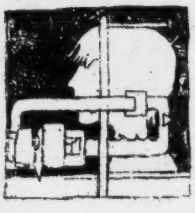


And ahhh'd.

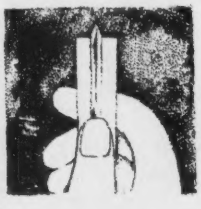
And needled.



And measured.



And tested.



And charted.

And treated.

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For more information, see your local health or welfare office or write Commissioner, Medical Services Administration, Washington, D.C. 20201.

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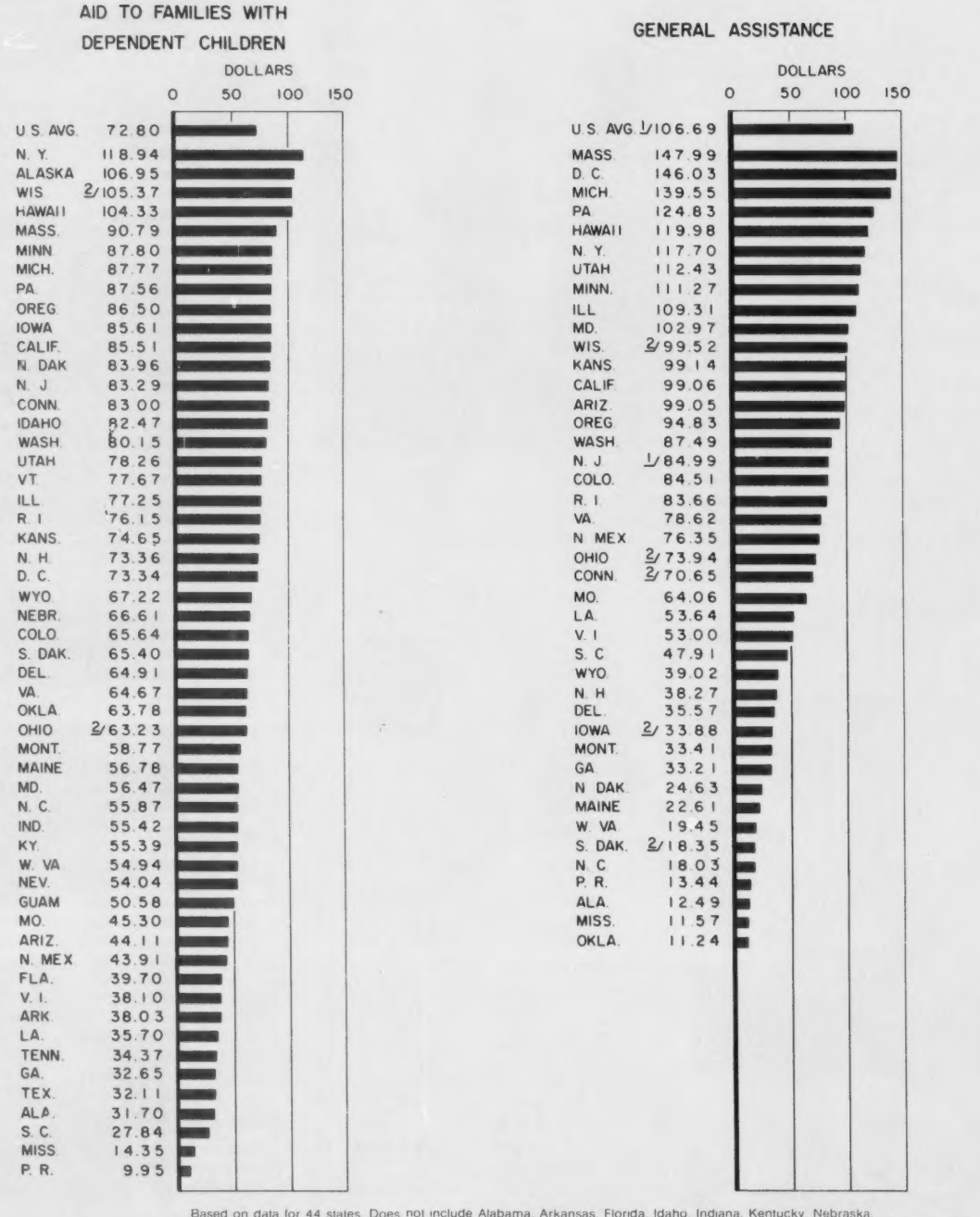

Based on data for 44 states. Does not include Alabama, Arkansas, Florida, Idaho, Indiana, Kentucky, Nebraska, Nevada, Tennessee, Texas, Vermont and Guam. Data for New Jersey include assistance to the working poor program. Estimated

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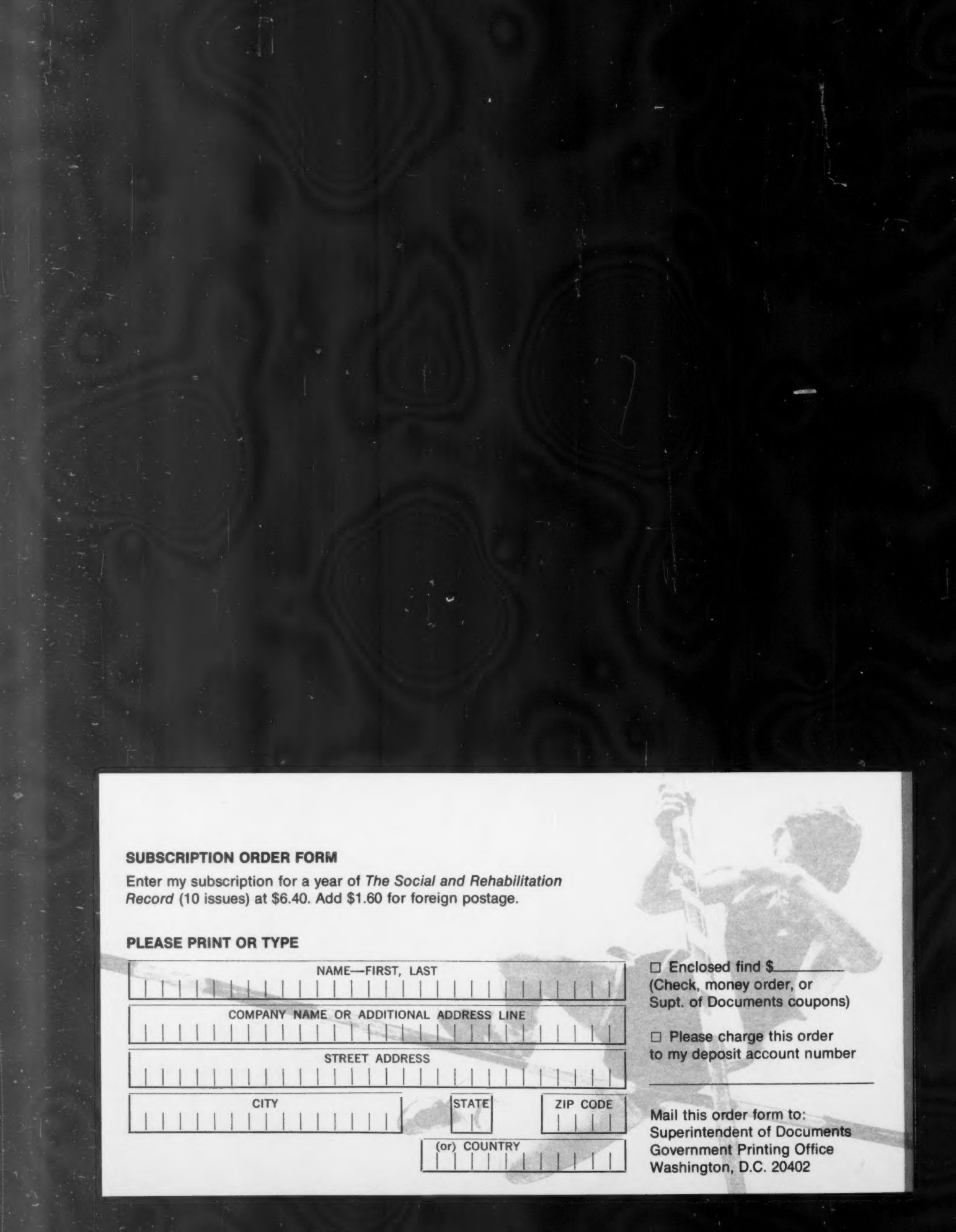

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